

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>TN1912</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/04/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>IMPERIAL GARDENS HEALTH AND REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>306 W DUE WEST AVE MADISON, TN 37115</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
N 000	Initial Comments  During complaint investigation of #TN00029059 conducted on January 4, 2012, at Imperial Gardens Health and Rehabilitation, no deficiencies were cited in relation to the complaint under 1200-8-6, Standards for Nursing Homes.	N 000			

Division of Health Care Facilities

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

DATE FORM

6899

PCSC11

If continuation sheet 1 of 1